3-Hole 1/4 1 3/8 c-to-c

MAGNETIC RESONANCE IMAGING (MRI)
ABDOMEN QUESTIONNAIRE

Print Name: _____ Date: _____

1.) Reason you are having this MRI scan, include any recent or new complaints:

_____

_____

How long have your symptoms been present? _____

2.) What are your major symptoms? (pain, mass, infection, etc…)

_____

_____

For how long? _____

3.) Do you have a history of cancer? _____ If yes, what type? _____

Did the treatment include:

Radiation therapy? ☐ Yes ☐ No

Chemotherapy? ☐ Yes ☐ No

If yes to radiation therapy, what part of your body? _____ If yes, when? _____

4.) Have you had any other previous surgeries? _____ If yes, please list type of surgery and date:

_____ _____

_____ _____

5.) Are you scheduled or will you be scheduled in the future for a transplantation of an organ?

If yes, what body part (or organ)? _____

6.) Have you had any previous imaging studies of this area? ☐ Yes ☐ No

Type of Study:	**Date**	**Facility**
Radiographs (X-rays)	_____	_____
Angiogram	_____	_____
Computed Tomography (CT)	_____	_____
Nuclear Medicine (Bone Scan)	_____	_____
MRI	_____	_____
Other	_____	_____

MRI Technologists Notes:

_____

_____

_____

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

51219 (Rev. 07/09)

ABDOMEN QUESTIONNAIRE

OUTPATIENT QUESTIONNAIRE/ASSESSMENT
MAGNETIC RESONANCE IMAGING (MRI) DEPARTMENT

Patient Information and History

Name:_____ Date of Birth: _____ Today's Date: _____

Ordering Physician: _____

Exam(s) being done today: _____

Briefly explain to the best of your knowledge the reason for this exam:_____

_____

_____

What is the primary language spoken?_____

1. Do you need assistance walking and/or standing? ☐ Yes ☐ No
2. Are you "at risk" of falling? ☐ Yes ☐ No
3. Have you had any recent falls? ☐ Yes ☐ No

   Date of recent fall: _____ Briefly explain: _____

   _____

4. Is there anyone with you today? ☐ Yes ☐ No
5. Do you have any known allergies to latex products? ☐ Yes ☐ No
6. Are you allergic to any medications? ☐ Yes ☐ No

   If yes, what type(s)?:_____

7. Are you diabetic? ☐ Yes ☐ No

Individualized Patient Care

What is one thing I can do for you to make sure you receive **very good** care today?

_____

_____

Are there any **special needs/considerations** that we should know about?

_____

_____

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

51220 (Rev. 06/09)

OUTPATIENT QUESTIONNAIRE & ASSESSMENT

RAD-024

OUTPATIENT QUESTIONNAIRE/ASSESSMENT
MAGNETIC RESONANCE IMAGING (MRI) DEPARTMENT

Medication List

Please list all medications you are currently taking:

Date	Medication Name	Dose	Frequency

Patient / Patient Caregiver Signature **Date**

Clinician Signature (i.e. Nurse) **Date**

Clinical Signature (i.e. MRI Technologist) **Date**

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

51220 (Rev. 06/09)

OUTPATIENT QUESTIONNAIRE & ASSESSMENT

RAD-024

MAGNETIC RESONANCE IMAGING (MRI)
SCREENING FORM FOR PATIENTS

The information requested on this form is very important. Please answer all questions as thoroughly as possible.
The patient or patient's legally authorized representative is responsible for the accuracy of the requested information.

Patient Name (printed): _____ **Weight:** _____ **Height:** _____

Do you have any of the items or conditions listed below? Please check "Yes" of "No" for each item or condition.

Yes	No		Yes	No	
		Cardiac Pacemaker			Penile Implant
		Implanted Cardioverter (Heart) Defibrillator			Neurostimulation system
		Stent, Coil or Filter (circle all that apply)			Ph Graph Probe
		Location: Date:			Bone growth / Bone Fusion Stimulator
		Aneurysm Clips Location:			Middle Ear/Cochlear Implant:
		Zenith Cook, (Abdominal) Stent Graft			Left Right Both
		Surgical staples, clips or metallic sutures			Hearing Aid
		Carotid Artery Clips Date:			Prosthesis of: Joint, Extremities or Eyes
		Internal electrodes or wires			(circle all that apply) Date:
		Artificial Heart Valve Date:			Implanted drug infusion pump
		Shunt: Spinal or Ventricular			Medication Pump and /or Medication Patch
		Thermodilution Swan-Ganz Catheter			Metal Fragments (Shrapnel or Gunshot wound)
		Magnetically-activated implant or device?			Location: Date:
		Silver impregnated wound dressing			Tattoos or Permanent makeup Location:
		Fractured bones or spine treated with:			Body Piercing Location:
		Metal Rod Date:			Date of your last menstrual period:
		Metal Plates Date:			Do you have an Intrauterine device (I.U.D.)?
		Metal Pins Date:			Are you Pregnant or trying to get pregnant?
		Screws Date:			Are you currently Breast Feeding?
		Metal in eyes Left / Right / Both			Are you claustrophobic (fear of tight places?)
		Eyelid spring or wire			Do you have any kidney problems?
		Scleral buckles			Allergic Reactions to Intravenous (IV) Contrast?
		Sickle Cell or Hemolytic Anemia			Ingested camera pill?
		Tissue Expander Date:			Other implants? Date:

*** No one should enter the MRI scan room with:** • Watch • Metal Zippers • Firearms • Removable Dental Work • Pens • Hearing Aid • Keys/Coins • Pocket Knife • Hairpins • Belt Buckle • Bra • Purse, Wallet, Money Clip, Credit Cards

Signature of Person completing the form: _____

Form completed by: ☐ **Patient** ☐ **Relative** ☐ **Care Giver** ☐ **Other:** _____

MRI STAFF: Signatures of person(s) reviewing the MRI Screening Form for Patients:

1.) _____ **R.T. 2.)** _____

Were X-Ray's obtained? ☐ **Yes** ☐ **No** **Date** _____ **Time** _____ **Filmed cleared by:** _____ **M.D.**

Contrast Type: _____ **Amount:** _____ **ml** **Lot #:** _____ **Exp. Date:** _____

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

51222 (Rev. 12/09)

SCREENING FORM FOR PATIENT

BAYLOR HEALTH CARE SYSTEM
PATIENT HISTORY FOR CONTRAST MEDIA

Patient Name:_____ Date of birth: _____ Height: _____ Weight: _____

In order to assess your risk of complications and reduce risk for a contrast media allergic reaction please complete sections 1-3 below:

1. ***Please indicate if you have one of the following *:***

- ❑ History of "kidney disease" as an adult or family history of kidney problems
- ❑ History of kidney transplant
- ❑ History of liver disease
- ❑ Diabetes
- ❑ Paraproteinemia syndromes or diseases (e.g. myeloma)
- ❑ Collagen vascular disease (e.g. Lupus)
- ❑ Recent contrast study (e.g. within the last 7 days)
- ❑ Recent surgeries? If yes, please list: _____
- ❑ Sickle cell disease

Certain medications:

- ❑ Metformin or metformin-containing drug combinations (Metformin, Avandamet, Glucophage, Glucophage XR, Actoplus Met)
- ❑ Regular use of nephrotoxic antibiotics, such as aminoglycosides, or non-steroidal anti-inflammatory drugs (e.g. Motrin, Aleve)

**** If you checked any of the boxes above, please inform your technologist now. You may require special instructions and further blood test(s) to assess your kidney function prior to receiving intravenous (IV) contrast media.***

2. ***Have you ever had an allergic reaction to intravenous contrast*** *(e.g. iodine, gadolinium)**?*** ❑ **YES** ❑ **NO**

If "YES", please describe*: _____

****If "YES", based on your reply, you may require pre-medication prior to receiving IV contrast, no IV contrast, or alternative imaging.***

3. ***Do you have a history of the following medical conditions:***

- ❑ Asthma (if you have <u>active</u> asthma, bronchospasm, or bronchitis requiring treatment, please inform your technologist **now**)
- ❑ Cardiac Disease (angina, congestive heart failure, aortic stenosis, hypertension, primary pulmonary hypertension, severe but well compensated cardiomyopathy)
- ❑ History of allergic (anaphylactic) reaction to one or more allergens

Signed: _____ Date:_____ Time: _____
(Patient, Parent or Guardian)

To be filled out by the technologist performing your exam

_____ Exam Performed Per Protocol _____ Exam Performed Per Physician / Name: _____

Contrast IV - Type/Amount/Rate/Site: _____ Contrast Oral - Type/Amount:_____

Creatinine: _____ Result Date: _____ Estimated Glomerular Filtration Rate: _____

Technologist: _____ Date:_____ Time: _____

BAYLOR HEALTH CARE SYSTEM

BHCS-49045 (Rev. 02/10)

PATIENT HISTORY FOR CONTRAST MEDIA